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Testimony for Public Hearing
Committee on Insurance and Real Estate
February 25, 2010

Submitted By
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Raised Bill No. 194 (Committee on Insurance and Real Estate) - An Act Concerning Rate Approvals for Individual Health Insurance Policies

Testimony respectfully submitted in opposition to Raised Bill No. 194 (Committee on Insurance and Real Estate) - An Act Concerning Rate Approvals for Individual Health Insurance Policies.

I. Aetna Supports Health Care Reform

Aetna, Inc. is a national health insurance company headquartered in Connecticut. Aetna has about 7, 200 employees in Connecticut and paid $68.8 million in state and local taxes. We cover over 455,000 individuals in the state through our health insurance coverage and are a significant contributor to the overall state economy.

Aetna has been at the forefront of advocating health care reform to address the pressing needs of Americans in Connecticut and across the nation. It is important that health care reform address:

- **Access:** Aetna supports solutions that include insurance reforms, an individual responsibility requirement to maintain coverage, and subsidies to make coverage affordable. We support assuring that all individuals – both the sick and the healthy – have access to coverage without facing pre-existing condition exclusions.

  Making this happen means we need to get everyone covered and insurance reforms need to be combined with an individual coverage requirement. Otherwise, insurance premiums will increase for everyone as the healthy drop coverage and only the sick maintain coverage. States such as Maine and New York have demonstrated the problems with enacting insurance reforms in a voluntary market. A 25 year old would pay $1,177 per month for a policy for an HMO plan in Buffalo, New York. Similarly, a 25 year old in Maine would pay $934 per month for a standard HMO plan.[1]

  Contrast those high premiums with the $167 per month that a healthy 25 year old would pay in Connecticut for a similarly structured individual policy[2] and the $632 per month that an unhealthy 25 year old would pay for high risk pool coverage.[3]

- **Quality:** Too often, today's system does not provide the right care at the right time for patients. Peter Orszag, director of the Office of Management and Budget, has stated that the U.S. spends approximately $700 billion on unnecessary tests and services.[4] Approximately 30% of healthcare is

[1] Based on information obtained from www.aetna.com.
[2] Based on information obtained from www.aetna.com.
[3] Based on information obtained from the Health Reinsurance Association of Connecticut.
[4] U.S. Congress. Senate Finance Committee. March 10, 2009. (testimony of Peter Orszag).

unnecessary (Kaiser Family Foundation 2009) and only 59% of patients receive the recommended standard of care. For instance:

- Only 83% of heart attack patients received beta blockers within 24 hours (2005)
- Only 40% of adults over the age of 40 received all three recommended services for diabetics (hemoglobin A1c measurement, dilated eye examination, and foot examination)

We need to stop paying for activity and start paying for quality outcomes that are aligned with medically recognized standards of care.

- **Cost:** Health insurance reform should address the underlying drivers of escalating premiums – medical prices and utilization, cost shifting from public programs, federal and state taxes, unhealthy lifestyles and adverse selection.

II. The Drivers Behind Rising Health Insurance Premiums

Health insurance premiums are impacted by a number of areas. Rising trends in each of these areas result in higher premiums. In particular, rising premiums are driven by:

- **Medical costs:** A recent investigation by the Massachusetts Attorney General found that medical price increases accounted for 80% of the growth in total medical expenses for one major payer. Further, they found that provider prices vary significantly with the disparity between lowest and highest paid providers as much as 200%. Price variations were correlated to market leverage -- ***not*** quality of care or the sickness or complexity of the population being served.[5]

  According to the Centers of Medicare and Medicaid Services' National Health Expenditures Survey, between 2003 and 2008, the major cost drivers are:
  - Hospital Services (41% of health care spending growth)
  - Physician services (38% of health care spending growth)
  - Pharmaceuticals (8% of health care spending growth)

  Premium growth has closely tracked the growth of overall health care costs. In fact, over the past decade, health care costs have increased about seven percent per year and premiums have increased about seven percent per year, according to the National Health Expenditures survey done each year by the actuaries at the Centers for Medicare and Medicaid Services (CMS) and reported regularly in the journal *Health Affairs*.[6]

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[5] Office of Massachusetts Attorney General, Investigation of Health Care Cost Trends and Cost Drivers _ Preliminary Report, January 29, 2010.

[6] Annual survey results can be accessed at: http://www.cms.hhs.gov/nationalhealthexpenddata.

- **Cost shifting:** Underpayments by Medicare and Medicaid result in a typical insured family paying almost 11% more in premiums. The continual underpayments by public programs makes private health insurance more expensive than it otherwise would be.[7]

  In addition, a 2005 study by Families USA found that as much as $922 of the typical family premium is due to cost shifting from the uninsured who receive health care services but have no way to pay.[8]

- **Taxes:** Federal, state and local taxes paid by Aetna account for 4.5% of premium -- this amount is higher than what Aetna retains in profit and does NOT include the myriad of additional taxes that would be levied under the federal Senate bill. In total, Aetna paid $1.2 billion in federal and state taxes in our most recent tax filing.

- **Unhealthy Lifestyles:** Unhealthy lifestyle choices are driving an increase in chronic diseases such as diabetes, cardiovascular disease and cancer. In particular, these diseases are caused by:

  - *Obesity:* 67% of Americans (59.7% of Connecticut residents) are overweight or obese, and one in three children are obese.[9] Obesity related costs totaled approximately $147 billion[10] last year and medical spending for obese workers can be up to 117% greater than spending for workers with a normal weight.

  - *Smoking:* Despite extensive education over the last decade, 18.3% of American women[11] and 23.1% of American men still smoke.[12] Of significant concern is the fact that 20% of teenagers smoke[13] – setting themselves up for a lifetime of poorer health. Smoking accounts for approximately $157 billion in annual health-related economic losses.[14]

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[7] Milliman, Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers, December 2008

[8] Families USA, "Paying a Premium." 2005.

[9] In Connecticut, one in four children are obese (2007). US data: Centers for Disease Control and Prevention. National Center for Health Statistics. 2005-2006; CT data: www. Statehealthfacts.org, Kaiser Family Foundation (2007, 2008).

[10] Finkelstein, E. et al. "Annual Medical Spending Attributable to Obesity: Payer-And Service-Specific Estimates/" *Health Affairs*. 2009.

[11] Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey Raw Data, 2008.

[12] Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey Raw Data, 2008.

[13] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance—United States, 2007. Morbidity and Mortality Weekly Report. June 6, 2008; 57(SS-04).

[14] Centers for Disease Control and Prevention. Annual Smoking—Attributable Mortality, Years of Potential Life Lost, and Economic Costs, 1995-1999. April 12, 2002.

- **Adverse Selection:** A recent letter from the National Association of Insurance Commissioners explains that the individual market is particularly sensitive to adverse selection because individuals are responsible for paying their entire premiums. According to the NAIC letter, "In weak economic times, young and healthy individuals tend to drop or reduce coverage at greater rates than older and sicker individuals, leaving risk pools with higher average costs. This adverse selection compounds the effects of high medical trend costs."

III. Prior Approval: The Issues that Should Be Considered.

At the same time that we support meaningful health care reform, we caution against proposals that are misguided and would have negative unintended consequences. One such problematic initiative would be new prior approval legislation for health insurance premiums.

Prior approval of insurance premiums fails to address the underlying drivers of health care costs – medical prices and utilization. A 2004 Rand report found that in the long run, prior approval's suppression of premium growth could result in lower quality products and reduced choice as insurers exit the market.

In addition, prior approval leads to the politicization of rate setting. In New York, political pressure led to inadequate premiums that jeopardized the solvency of key insurers like Empire in the individual health insurance market. Also, politicization of rate increases precipitated a malpractice insurance crisis. Eventually, the NY DOI said, "After years of artificially low rate increases...this increase is necessary to avoid further financial deterioration of the companies and perhaps an irreversible crisis in an already severely distressed market. As a result of artificially low rates, combined with the failure to effectuate needed reforms to address the root cause of high medical liability costs, insurance companies now face the real prospect of insolvency."

In addition, the NY insurance department was unable to process rate applications in a timely manner under prior approval rules. On average, rate approvals were not completed until four days *after* their effective dates, resulting in retroactive premium charges to customers. Filings for another insurer were not approved until five and seven months after the product effective dates.

We urge regulators and policymakers to work together to address underlying cost issues, as opposed to superficially addressing the symptom of rising medical prices and utilization. Prior approval will result in less competition, insurance products that don't meet consumer needs and will make it exceptionally challenging for companies like Aetna to stay in our home market.

IV. Aetna's Commitment to the Health and Well-being of Customers

Aetna has developed a myriad of programs to further the health and well-being of customers. In particular, Aetna has made a significant investment and commitment to:

- **Technology Advancement:** Aetna has invested $ 1.8 billion since 2005 to improve technology systems. These investments empower consumers with and improve health care quality. As Aetna Members, consumers have access to the secure member website, Aetna Navigator, where they may obtain actual prices for particular services in their area, as well as drug costs at participating pharmacies. The site also allows them to estimate how quickly they will reach the plan deductible, manage their health savings and estimate their out-of-pocket costs. As a result, consumers make more informed treatment choices and are more financially secure in the decisions they make.

  Aetna also believes that HIT can facilitate vast improvements in individuals' health care experiences by offering them a clearer picture of their own health, more coordinated interactions with providers and better, safer health outcomes. Aetna's "Care Engine" technology -- our unique clinical-decision support technology provided through ActiveHealth Management -- analyzes more than 18 million individual, comprehensive electronic patient medical records. By incorporating diagnosis and procedure claims data, pharmacy and lab data, clinical feedback from physicians and other patient data, the technology creates continually refreshed patient-centric electronic medical records. These data are then applied against an ever expanding set of evidence-based clinical rules to generate "Care Consideration" alerts that are then sent to treating physicians and patients through a variety of electronic and non-electronic means. These alerts are having a measurable impact on both the quality and value of patient care, especially in chronic disease patients where effective care coordination makes a tremendous difference.

- **Quality Enhancement:** Aetna has pursued extensive partnerships with providers to improve quality through its Aexcel Network and Aetna Institutes. In Aexcel, specialists who have met certain clinical quality and efficiency standards are recognized. This high performance network is associated with high-quality care that can save up to four percent in medical costs annually. Aetna Institutes™ facilities are publicly recognized, high-quality, high-value health care facilities. Our Institutes of Quality for Bariatric Surgery, for example, have achieved exceptional outcome results for our members, resulting in less complications, fewer readmissions, and medical costs in the year post surgery that are 15 percent lower than the year prior.

  Aetna also is working to incentivize health care facilities, physicians and other health care professionals to take action to prevent medical errors by changing the way they are paid when medical errors do occur. Aetna's policy is

consistent with the recommendations of national organizations, such as the Leapfrog Group and the National Quality Forum, and requires that health care facilities take specific steps when any of 28 serious reportable events, or SREs, occur. Physicians and other health care professionals are required to waive all charges related to three "Never Events" and health care facilities are also required to waive charges that are directly and solely related to eight other specific SREs and are not allowed to bill members for charges related to these events.

- **Value Maximization:** We understand the need for affordable products and strive to achieve value for our customers. To this end, Aetna subscribes to a zero tolerance policy on health care fraud that has saved millions of dollars. The Special Investigations Unit (SIU), a team of professional investigators, is responsible for the company's health care fraud and abuse program. SIU maintains a 24 hour hot line to receive fraud tips and uses the IBM Fraud and Abuse Management System (FAMS) to model provider behavior and identify outliers based on elements chosen from a library of over 8,000 discrete measures. Aetna's Fraud and Abuse Case Tracking System (FACTS), a proprietary fraud and abuse case tracking system is used to document all details of investigations. Aetna is also a founding member of the National Health Care Anti-Fraud Association and the NY Department of Insurance recently referred to the Aetna SIU as "the gold standard by which all SIUs should be measured."

  Aetna Health Connections Disease Management helps people with chronic conditions obtain the treatment and preventive care they need. Aetna's clinicians help members understand and follow their doctors' treatment plan and better manage ongoing conditions.

  Through disease management, patients have had 26% fewer inpatient admissions for diabetes, coronary artery disease, congestive heart failure and stroke. In addition, participants are more likely to continue necessary medications after a heart attack, control asthma through proper prescription adherence and maintain proper blood pressure and cholesterol levels.

V. Conclusion

Aetna supports health care reform that addresses the most urgent issue for Americans -- the need to address the core underlying drivers of health care costs. We look forward to working with state and federal legislators to support reform that improves access, as well as addresses rising medical prices, cost shifting from public programs, escalating taxes and unhealthy lifestyle choices. In addition, we think it is important for states to avoid problematic reforms such as prior approval that could lead to solvency and choice problems for consumers.

While we advocate health care reform, we are not waiting for the states or the federal government to act. We already are partnering with providers and others to drive positive change in this voluntary environment, including administrative simplification and payment reform efforts, among others. We look forward to continuing to working with all stakeholders to further improvement in this critical area for Connecticut and the United States.